

PRACTICE ORIENTATION AND AGREEMENT

YOUR RIGHTS AND RESPONSIBILITIES AS A CLIENT

- ◆ You have the right to receive services from clinicians who adhere to the professional code of ethics of their respective disciplines.
- ◆ You have the right to receive services in accordance with Federal and State regulations and accreditation standards governing behavioral health programs.
- ◆ You have the right to privacy and confidentiality regarding the service you receive. All information about you and your treatment, whether written or oral, is protected under Federal and State laws, including the HIPAA Privacy Act.
- ◆ You have the right to be provided informed consent to services offered to you.
- ◆ You have the right to refuse services at any time. You have the right to withdraw your consent to receive services and discontinue services at any time. You have a right to information concerning your treatment/care.
- ◆ You have the right to know treatment recommendations and the possible outcomes if you choose not to follow these recommendations.
- ◆ You have the responsibility to assist in planning your treatment at every stage.
- ◆ You have the right to express any concerns or complaints regarding the services you receive. We encourage you to first contact your clinician to resolve any issues. You may also contact the Rights Advisor, Lawrence T. Wentworth, PhD for assistance.
- ◆ You have the responsibility to be timely for your appointments. Late arrivals may result in rescheduled appointments.
- ◆ You have the responsibility to arrive for all scheduled sessions, or to notify us 24 hours in advance if you wish to cancel an appointment. **You may be charged a practice fee, up to \$125, for non-cancelled appointments**, where an emergency was not involved, as insurance companies and other third-party payers do not cover missed appointments.
- ◆ You are responsible for any fees that may be charged to you at the time of service and knowing your insurance benefits coverage.
- ◆ Your case will be closed following 45 days of inactivity, unless arrangements have been made.
- ◆ You have the right to know we may call the police if someone comes to the practice under the influence of drugs or alcohol and tries to leave the practice.
- ◆ You have the right to know that no member of our staff is allowed to date current or former clients of the practice.
- ◆ You have the right to know that staff and therapists are not allowed to accept gifts from clients of the practice.

SERVICES OFFERED

Wentworth and Associates offers an array of mental health services. These services include: individual psychotherapy, group therapy, family therapy, marital therapy, psychological testing, Psychiatric evaluations and medication therapy are also available on site. Your clinician will provide you with a detailed description of the nature of services and expected benefits and potential risks.

CLIENT INPUT

Wentworth and Associates will be asking you for ongoing feedback regarding the quality and effectiveness of services you receive. We will ask you to complete clinical outcome questionnaires and satisfaction surveys periodically. We will also review and/or investigate any complaints or suggestions you may have (contact Rights Advisor). Your feedback is considered an important part of treatment/care.

OPERATIONS

Office hours are usually between 7AM and 10PM, 7 days a week. Not all clinicians are available during all open hours. Appointment dates and times and after hours contacts shall be arranged between you and your treating clinician. An outdoor elevator is located in the back parking lot of the building for individuals with physical disabilities. In emergencies, you can contact or go (if able) to the nearest crisis center (Macomb County Crisis Center at 586-307-9100; Oakland Crisis Center at 248-456-0909). You may also contact the nearest emergency room. We practice in a non-smoking environment. Illicit drugs and weapons are not allowed on the premises. Persons in possession of either will be asked to leave immediately.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our staff uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information is contained in a medical record that is the physical property of our organization.

How We May Use or Disclose Your Health Information For Treatment. We may use your health information to provide you with mental health treatment or services. For example, information obtained by a mental health care provider, such as a psychiatrist, psychologist, social worker, or other person providing mental health services to you, will record information in your record that is related to your treatment. This information is necessary for mental health care providers to determine what treatment you should receive. Mental health care providers will also record actions taken by them in the course of your treatment and note how you respond to the actions.

For Payment. We may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you of a third-party payer, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For Health Care Operations. We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the clinical staff, risk or quality improvement personnel, and other to:

- evaluate the performance of staff;
- assess the quality of care and outcomes in your cases and similar cases;
- learn how to improve our facilities and services; and
- determine how to continually improve the quality and effectiveness of the mental health care we provide.

Appointments. We may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund Raising. We use your information to contact you to raise funds for our organization.

Required by Law. We may use and disclose information about you as required by law. For example, we may disclose information for the purposes:

- for judicial and administrative proceedings pursuant to legal authority;
- to report information related to victim of abuse, neglect or domestic violence; and
- to assist law enforcement officials in their law enforcement duties.

Public Health. Your health information may be used or disclosed for public health authorities or other legal authorities to prevent or

control disease, injury, or disability or for other health oversight activities.

Decedents. Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Organ/Tissue Donation. Your health information may be used or disclosed for cadaveric organ, eye or tissue donation.

Research. We may review your mental health information to determine if your protected health information is needed for research projects. To the extent that information is needed, an institutional review board or privacy board will review the research proposal and established protocols to ensure the privacy of your health information.

Health and Safety. Your health information may be disclosed to avert a serious threat to the health and safety of you or any other person pursuant to applicable law.

Government Functions. Your health information may be disclosed for specialized government functions such as protection of public officials or reporting to various branches of the armed forces.

Workers' Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation.

Other Uses. Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent we have relied on it.

Your Health Information Rights

You have the right to:

- request restriction on certain uses and disclosures of your information as provided; however, we are not required to agree to a requested restriction;
- to obtain a paper copy of this notice of Privacy Practices upon request;
- inspect, and obtain a copy of your health record as provided by law;
- request communications of your health information by alternative means or at alternative locations;
- revoke your authorization to use or disclose health information except to the extent we have already taken action based upon your authorization; and
- receive an accounting of disclosures made of your health information.

If you have any questions or complaints, please contact the Privacy Official at 586-997-3153. You may also complain to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

We reserve the right to change our privacy practices and to make the new provisions effective for all protected health information we maintain. Revised notices will be made available to you at our offices, and via mail.

Patient's Name: _____ DOB: ____/____/____ SS#: ____-____-____
--

COORDINATION OF CARE CONSENT FORM

I, _____, hereby **authorize** **do not authorize**
Wentworth & Associates, P.C. to release and/or obtain confidential information contained in: **my**
 my child's/ward's patient records to and from the following physician(s):
(If no Primary Care Physician, check here and sign below.)

My Primary Care Physician: _____
Physician's Name

Address: _____

Information to be disclosed:

- Diagnoses: _____
- Medication Information: _____
- Assessments/Testing Information: _____
- Other: _____

Instructions/Requests:

Purpose of such a disclosure:

- Coordination of Care
- Other: _____

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

The use of this consent by Wentworth & Associates, P.C. is effective for one year from the date of signature, and may be revoked by myself, in writing at any time. This consent is being signed voluntarily and under no circumstances is a precondition of treatment.

Please Send Requested Information to:

Requesting Clinician's Name

Wentworth and Associates, P.C. OR FAX: 586-997-4956
11111 Hall Road, Suite 303
Utica, Michigan 48317

This form was Mailed Faxed Other (specify): _____ to the PCP named above.

ORIGINAL: Clinical Record
Rev. 8/16/06

COPY: Primary Care Physician

Wentworth & Associates, P.C.
11111 Hall Road, Suite 303
Utica, MI 48317
Phone: 586-997-3153

Youth Outcome Questionnaire (YOQ 30)

Initials: _____ **Therapist:** _____ **Date:** _____

Instructions: You may discover that some of the items do not apply to your current situation. If so, please do not leave these items blank, but check the “never/almost never” category. When you begin to complete the YOQ-30, you will see that you can easily make yourself as healthy or unhealthy as you wish. Please do not do that. If you are as accurate as possible, it is more likely you will be able to receive the help that you are seeking.

READ each statement carefully. Check the number that best describes how true the statement has been during the past 7 days. Check only one answer for each statement.

Directions for parents/guardians completing the questionnaire **for children under 12:** Respond to the statements as if each began with “My child...” or “My child’s...” rather than “My..” or “I..” It is important that you answer as accurately as possible based on your own observation and knowledge.

PERSON COMPLETING THE FORM (Please Circle):

ADOLESCENT PARENT/GUARDIAN OTHER

1. **I have headaches or feel dizzy.**
 0 Never/Almost Never 1 Rarely 2 Sometimes 3 Frequently 4 Almost Always
2. **I don't participate in activities that used to be fun.**
 0 Never/Almost Never 1 Rarely 2 Sometimes 3 Frequently 4 Almost Always
3. **I argue or speak rudely to others.**
 0 Never/Almost Never 1 Rarely 2 Sometimes 3 Frequently 4 Almost Always
4. **I have a hard time finishing my assignments or do them carelessly.**
 0 Never/Almost Never 1 Rarely 2 Sometimes 3 Frequently 4 Almost Always
5. **My emotions are strong and change quickly.**
 0 Never/Almost Never 1 Rarely 2 Sometimes 3 Frequently 4 Almost Always
6. **I have physical fights (hitting, biting, or scratching) with family or others my age.**
 0 Never/Almost Never 1 Rarely 2 Sometimes 3 Frequently 4 Almost Always
7. **I worry and can't get thoughts out of my mind.**
 0 Never/Almost Never 1 Rarely 2 Sometimes 3 Frequently 4 Almost Always
8. **I steal or lie.**
 0 Never/Almost Never 1 Rarely 2 Sometimes 3 Frequently 4 Almost Always
9. **I have a hard time sitting still (or I have too much energy).**
 0 Never/Almost Never 1 Rarely 2 Sometimes 3 Frequently 4 Almost Always
10. **I use drugs or alcohol.**
 0 Never/Almost Never 1 Rarely 2 Sometimes 3 Frequently 4 Almost Always
11. **I am tense and easily startled (jumpy)**
 0 Never/Almost Never 1 Rarely 2 Sometimes 3 Frequently 4 Almost Always

12. **I am sad or unhappy.**
 0 Never/Almost Never 1 Rarely 2 Sometimes 3 Frequently 4 Almost Always
13. **I have a hard time trusting family members or other adults.**
 0 Never/Almost Never 1 Rarely 2 Sometimes 3 Frequently 4 Almost Always
14. **I think that others are trying to hurt me even though they are not.**
 0 Never/Almost Never 1 Rarely 2 Sometimes 3 Frequently 4 Almost Always
15. **I have threatened to run away from home or have run away from home.**
 0 Never/Almost Never 1 Rarely 2 Sometimes 3 Frequently 4 Almost Always
16. **I physically fight with adults.**
 0 Never/Almost Never 1 Rarely 2 Sometimes 3 Frequently 4 Almost Always
17. **My stomach hurts or I feel sick more than others my age.**
 0 Never/Almost Never 1 Rarely 2 Sometimes 3 Frequently 4 Almost Always
18. **I don't have friends or I don't keep friends very long.**
 0 Never/Almost Never 1 Rarely 2 Sometimes 3 Frequently 4 Almost Always
19. **I think about suicide or feel I would be better off dead.**
 0 Never/Almost Never 1 Rarely 2 Sometimes 3 Frequently 4 Almost Always
20. **I have nightmares, trouble getting to sleep, oversleeping, or waking too early.**
 0 Never/Almost Never 1 Rarely 2 Sometimes 3 Frequently 4 Almost Always
21. **I complain about or question rules, expectations, or responsibilities.**
 0 Never/Almost Never 1 Rarely 2 Sometimes 3 Frequently 4 Almost Always
22. **I break rules, laws, or don't meet others' expectations on purpose.**
 0 Never/Almost Never 1 Rarely 2 Sometimes 3 Frequently 4 Almost Always
23. **I feel irritated.**
 0 Never/Almost Never 1 Rarely 2 Sometimes 3 Frequently 4 Almost Always
24. **I get angry enough to threaten others.**
 0 Never/Almost Never 1 Rarely 2 Sometimes 3 Frequently 4 Almost Always
25. **I get in trouble when I am bored.**
 0 Never/Almost Never 1 Rarely 2 Sometimes 3 Frequently 4 Almost Always
26. **I destroy property on purpose.**
 0 Never/Almost Never 1 Rarely 2 Sometimes 3 Frequently 4 Almost Always
27. **I have a hard time concentrating, thinking clearly, or staying on task.**
 0 Never/Almost Never 1 Rarely 2 Sometimes 3 Frequently 4 Almost Always
28. **I withdraw from my family and friends.**
 0 Never/Almost Never 1 Rarely 2 Sometimes 3 Frequently 4 Almost Always
29. **I act without thinking and don't worry about what will happen.**
 0 Never/Almost Never 1 Rarely 2 Sometimes 3 Frequently 4 Almost Always
30. **I feel that I don't have any friends or that no one likes me.**
 0 Never/Almost Never 1 Rarely 2 Sometimes 3 Frequently 4 Almost Always

CHILD & ADOLESCENT BACKGROUND QUESTIONNAIRE
(Ages 17 and under)

Purpose of this questionnaire: The purpose of this questionnaire is to obtain a comprehensive picture of your child/adolescent's background. In psychotherapy, obtaining background information is often necessary, as it permits a more thorough understanding of one's present difficulties. By completing these questions as fully and as accurately as your can, you will facilitate your therapeutic program. Please answer these questions in your own time, rather than using your actual consulting time. If there are any questions that you prefer not to answer, please write, "do not care to answer."

Please be aware that case records are strictly confidential. **No one outside of the Wentworth & Associates, P.C. staff is permitted to see your case record without your permission.**

How did you come to be referred to me or Wentworth & Associates? _____

Date: _____ Phone: _____ Home: _____

Work: _____

Mobile: _____

Name: _____

Beeper: _____

Address: _____

Email: _____

City, _____ State, _____ Zip: _____

Date of birth: _____ Social Security Number: _____

Primary Insurance

Company: _____

Effective date: _____ Contact number: _____ Group Number: _____

Full name of subscriber: _____ Relationship: _____ Subscriber's DOB _____

Subscriber's place of employment: _____

Secondary Insurance

Company: _____

Effective date: _____ Contact number: _____ Group Number: _____

Full name of subscriber: _____ Relationship: _____ Subscriber's DOB _____

Subscriber's place of employment: _____

Person completing form for this child: _____

Relationship to child: _____

Child's Name: _____ DOB: _____ Today's Date: _____

Sex: ___ M ___ F Age: _____ Ethnic Background: _____ Religious Beliefs: _____

Phone#: _____ Work Phone#: _____ Mobile/Other: _____

Allergies: _____

Current prescriptions & over-the-counter medications: _____

What are your current concerns about his child? Why is treatment being sought at this time?

How long has he/she been having these problems? _____

Why do you think the child is having these problems? _____

Please circle the word that describes the severity of the child's problems:
mild moderate severe extremely severe totally incapacitating

Are there any situations at home that might have an effect on child's behavior? _____

Has child threatened or attempted to harm themselves or others? ___ No ___ Yes

If yes, explain: _____

Whose idea was it to have the child brought to this clinic for help? _____

What are your/child's goals for therapy? _____

What would you/child like to do differently in your/their life? _____

FAMILY INFORMATION

Mother's Name: _____

Age: _____ Mother's Maiden Name: _____

Address: _____

Home Phone: _____ Work Phone: _____ Work Schedule: _____

Check one: ___ Biological Mother ___ Foster Mother ___ Adoptive Mother ___ Legal Guardian

Marital Status: ___ Married to child's Father ___ Separated ___ Divorced ___ Remarried ___ Single

___ Widowed ___ Living together

Employed: ___ No ___ Yes If yes, place of employment & job title: _____

Proprietary to Wentworth & Associates, P.C.

12/1/2006

Pg.

Father?s Name: _____
 Address: _____
 Home Phone: _____ Work Phone: _____ Work Schedule: _____
 Check one: Biological Father Foster Father Adoptive Father Legal Guardian
 Marital Status: Married to child?s Mother Separated Divorced Remarried Single
 Widowed Living together
 Employed: No Yes If yes, place of employment & job title: _____

Name of Step Parent(s) if applicable: _____
 Is Child adopted? No Yes
 If yes, age of child when she/he was adopted: _____ Does child know of the adoption? No Yes

Who does the child live with? Please provide the following information with respect to all household members:

NAME	AGE	SEX	RELATIONSHIP TO CHILD
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any brothers or sisters who do not live with the child:

NAME	AGE	SEX	RELATIONSHIP TO CHILD
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Other than parents, describe significant caretakers:

MEDICAL HISTORY

Child?s Primary Care Physician _____ Phone #: _____
 Address: _____
 Date child last saw physician: _____ Reason: _____
 If there is no regular physician, what do you do if the child needs to see a doctor? _____

Immunizations up to date? Yes No If no, explain: _____
 Child?s height: _____ weight: _____ appetite _____
 Please check: Recent weight gain? Loss? Does child Over-eat? Binge? Purge?



Please provide information with regard to the most recent following exams:

Exam	Age	Result
Last Vision Exam		
Last Hearing Exam		
Last Dental Exam		
Last TB skin Test		
Other		

Has child/adolescent ever had trauma to the head or closed head injury? If yes, please explain:

Has child/adolescent ever experienced loss of consciousness? If yes, please explain:

Please provide information on any surgical procedures and/or hospitalizations experienced by the child.

Include dates and results if known: _____

May we have permission to contact your child's physician or pediatrician to coordinate care? Yes No.

Substance abuse? No Yes Suspected If yes, or suspected, describe: _____

History of chemical/alcohol use: _____

Are there heavy drinkers in your family or origin? Yes No whom? _____

Has anyone expressed concern over child/adolescent's drinking or use of drugs? Yes No

Please explain: _____

Has child had treatment for alcohol or other chemical dependencies? If so, when and where?

Please check any of the following recreational chemicals that child/adolescent has used.

(Rarely? 1x month Often? once or twice per week Very often? daily or most days per week)

Past						Current				
	NEVER	TRIED	RARELY	OFTEN	VERY OFTEN	NEVER	TRIED	RARELY	OFTEN	VERY OFTEN
alcohol										
marijuana										
cocaine										
crack										
sedatives										
tranquilizers										
painkillers										
barbiturates										
heroin										
hallucinogens										
crystal meth										
ecstasy										
other										

How many times per week does child/adolescent drink or use chemicals? _____

How many drinks or how much substance does child/adolescent use per occasion? _____

Current and/or past conditions (please check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> ABDOMINAL PAIN | <input type="checkbox"/> FAINTING SPELLS | <input type="checkbox"/> NOSEBLEEDS |
| <input type="checkbox"/> ABNORMAL BALANCE | <input type="checkbox"/> FAST HEARTBEAT | <input type="checkbox"/> NUMBNESS/TINGLING |
| <input type="checkbox"/> ABNORMAL SENSE OF SMELL | <input type="checkbox"/> FEEL SHAKY OR TREMBLING | <input type="checkbox"/> PALPITATIONS |
| <input type="checkbox"/> ALLERGIES | <input type="checkbox"/> FREQUENT EAR INFECTIONS | <input type="checkbox"/> PNEUMONIA |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> FREQUENT INFECTIONS | <input type="checkbox"/> PREGNANCY |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> FREQUENT SORE THROAT | <input type="checkbox"/> RAPID HEART BEAT |
| <input type="checkbox"/> ASTHMA/WHEEZING | <input type="checkbox"/> FREQUENT URINATION | <input type="checkbox"/> RASHES/HIVES |
| <input type="checkbox"/> BLADDER TROUBLE | <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> RECTAL BLEEDING OR UNUSUAL, PAINFUL DISCHARGE |
| <input type="checkbox"/> BLEEDING/BRUISING | <input type="checkbox"/> GOUT | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> BLOOD IN URINE | <input type="checkbox"/> GYNECOLOGICAL PROBLEMS | <input type="checkbox"/> SCARLET FEVER |
| <input type="checkbox"/> BLOWS TO HEAD | <input type="checkbox"/> HEADACHES | <input type="checkbox"/> SEIZURES |
| <input type="checkbox"/> BLURRED/DOUBLE VISION | <input type="checkbox"/> HEARING PROBLEMS | <input type="checkbox"/> SHORTNESS OF BREATH |
| <input type="checkbox"/> BONE FRACTURES | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> SICKLE CELL DISEASE |
| <input type="checkbox"/> BOWEL DISTURBANCES | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> SINUS PROBLEMS |
| <input type="checkbox"/> BREATHING PROBLEMS | <input type="checkbox"/> HEPATITIS A,B OR C | <input type="checkbox"/> SKIN RASHES |
| <input type="checkbox"/> CANCER/TUMOR | <input type="checkbox"/> HERPES | <input type="checkbox"/> SORE THROAT/MOUTH OR TONGUE |
| <input type="checkbox"/> CHANGE IN APPETITE | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> SEXUAL PROBLEMS |
| <input type="checkbox"/> CHEST PAIN | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> CHRONIC COUGH | <input type="checkbox"/> IRREGULAR HEARTBEAT | <input type="checkbox"/> SWEATING |
| <input type="checkbox"/> CHRONIC FATIGUE | <input type="checkbox"/> JAUNDICE/HEPATITIS | <input type="checkbox"/> SWOLLEN FEET OR ANKLES |
| <input type="checkbox"/> CONSTIPATION/DIARRHEA | <input type="checkbox"/> JOINT PAIN | <input type="checkbox"/> THYROID DISEASE |
| <input type="checkbox"/> CONVULSIONS | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> TICS/TWITCHING |
| <input type="checkbox"/> COUGHING UP BLOOD | <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> TREMOR |
| <input type="checkbox"/> DENTAL PROBLEMS | <input type="checkbox"/> LOSS OF CONSCIOUSNESS | <input type="checkbox"/> ULCERS |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> LOW BLOOD SUGAR | <input type="checkbox"/> URINARY INFECTIONS |
| <input type="checkbox"/> DIARRHEA | <input type="checkbox"/> MANY CHEST COLDS | <input type="checkbox"/> VENEREAL DISEASE |
| <input type="checkbox"/> DIFFICULTY WITH SPEECH | <input type="checkbox"/> MEASLES/RUBELLA | <input type="checkbox"/> VISION CHANGE |
| <input type="checkbox"/> DIFFICULTY STARTING URINATION | <input type="checkbox"/> MENSTRUAL PAIN | <input type="checkbox"/> VOMITING BLOOD |
| <input type="checkbox"/> DIZZINESS | <input type="checkbox"/> MUSCLE SPASMS | <input type="checkbox"/> WEIGHT CHANGE |
| <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> MUSCLE WEAKNESS | <input type="checkbox"/> WHEEZING, GASPING |
| <input type="checkbox"/> ENCEPHALITIS | <input type="checkbox"/> NAUSEA/VOMITING | <input type="checkbox"/> WORSENING EYESIGHT |
| <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> NIGHT SWEATS | <input type="checkbox"/> OTHER |

DEVELOPMENTAL HISTORY: _____

Pregnancy/Labor/Delivery: _____ Term _____ Preterm Delivery _____ Birth Weight: _____
Pregnancy complications: _____ No _____ Yes
Prenatal exposure to drugs and/or alcohol? _____ No _____ Yes If yes, please explain _____

Complications at birth: _____ No _____ Yes
Maternal postpartum depression: _____ No _____ Yes

Infancy: (0-18 mths) Please check any that apply:
_____ Medical Problems _____ Feeding Problems _____ Sleep Problems _____ Unusual Fears
_____ Abnormal Response to Others _____ Parental Illness _____ Prolonged Separations
_____ Separation Problems _____ Head Banging or Self-Injury

Motor Milestones: Crawled: _____ Sat Unassisted: _____ Stood Unassisted: _____
Walked: _____

Toddlerhood: (18-36 mths) Please check any that apply
_____ Aggression _____ Tantrums _____ Self-Injury _____ Control Battles _____ Unusual or Intense Fears
_____ Sleep Problems _____ Night Terrors _____ Sleeps in Parental Bed _____ Prolonged Separations
_____ Separation Problems _____ Parental Illness

Toilet Trained: _____ Weaned: _____ Fed Self: _____ Dressed Self: _____ Spoke: _____

Preschool: (3-5 yrs) Please check any that apply:

____ Aggression ____ Tantrums ____ Self-Injury ____ Frequent Injuries ____ Unusual Fears
____ Toileting Difficulties ____ Sleep Problems ____ Oppositionality ____ Separation Problems
____ Prolonged Separations ____ Parental Illness ____ Fire Setting ____ Animal Cruelty
____ Bedwetting ____ Soiling of Underwear ____ Tied shoes ____ Help with Household Tasks

Childhood (6-12 yrs.)

<input type="checkbox"/> Medical Problems	<input type="checkbox"/> Aggression or self injury	<input type="checkbox"/> School changes and family moves
<input type="checkbox"/> School suspensions or expulsions	<input type="checkbox"/> Family Discord	<input type="checkbox"/> Fire setting or animal cruelty
<input type="checkbox"/> Sleep Problems	<input type="checkbox"/> Divorce or Parental illness/death	<input type="checkbox"/> Daytime or night-time wetting or soiling
<input type="checkbox"/> Police or legal problems	<input type="checkbox"/> School absences	<input type="checkbox"/> Sexual behavior
<input type="checkbox"/> Over or under weight	<input type="checkbox"/> School refusal	<input type="checkbox"/> Physical or emotional trauma
<input type="checkbox"/> Defiance towards adults	<input type="checkbox"/> School failure	
<input type="checkbox"/> Learning Problems	<input type="checkbox"/> Premature puberty	
<input type="checkbox"/> Running Away	<input type="checkbox"/> Unusual or Excessive Rituals	
<input type="checkbox"/> Friendship Problems		

Language and Reading Skills: ____ As expected ____ Having Problems

Coordination: Can: ____ Ride a Bike ____ Catch a Ball ____ Write in Cursive

Special Education Services: ____ No ____ Yes _____

Repeated or Accelerated a Grade: ____ No ____ Yes _____

Girls: First Menstrual Period: ____ Not Yet ____ Yes, Age _____

Boys: Voice Changes: ____ Not Yet ____ Yes, Age _____

Adolescence: (aged 13-18 years) Please check any that apply:

<input type="checkbox"/> Medical Problems	<input type="checkbox"/> Running Away	<input type="checkbox"/> Home or school moves
<input type="checkbox"/> School suspensions or expulsions	<input type="checkbox"/> School failure	<input type="checkbox"/> Sexual activity
<input type="checkbox"/> Sleep Problems	<input type="checkbox"/> School absences	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Police or legal problems	<input type="checkbox"/> Multiple school changes	<input type="checkbox"/> Physical or emotional trauma
<input type="checkbox"/> Weight gain or loss	<input type="checkbox"/> Friendship Problems	<input type="checkbox"/> Sexual identity or preference concerns
<input type="checkbox"/> Defiance and Anger hold grudges	<input type="checkbox"/> Family discord	<input type="checkbox"/> Self mutilation
<input type="checkbox"/> Growth Problems	<input type="checkbox"/> Divorce, parental illness/death	<input type="checkbox"/> Bizarre behavior or ideas
	<input type="checkbox"/> Financial strains	

Plays Sport: _____

Has Hobby: _____

Milestones Met:

Drivers License, age _____ Dating behavior, age _____ First Job, age _____

Special Education Services: ____ No ____ Yes:(explain) _____

Repeated or Accelerated a Grade: ____ No ____ Yes (explain) _____

Girls: First Menstrual Period: ____ Not Yet ____ Yes, Age _____

Boys: Voice Changes: ____ Not Yet ____ Yes, Age _____

Proprietary to Wentworth & Associates, P.C.

12/1/2006

Pg. 6 of 9

Has child ever been involved with police or juvenile court? ___ No ___ Yes If yes, please describe

Has child ever been physically abused? ___ No ___ Yes
Has child ever been sexually abused? ___ No ___ Yes
Has there ever been a Protective Service case opened related to this child or family? ___ No ___ Yes
Sexual/Gender Issues (Describe any sexual activity or gender concerns you have about this child)

Mental Health History

Has child had previous counseling, therapy, or psychiatric treatment? ___ No ___ Yes
If yes, please specify where, when: _____
Results of Treatment: _____

Has anyone in the child's family had any psychological or psychiatric problems? ___ No ___ Yes
If yes, describe _____
Has child been admitted to a state or local psychiatric facility? ___ No ___ Yes
If yes, indicate where and date of admission: _____

___ Residential ___ Partial Hospital Program ___ Outpatient ___ Case Management
___ Crisis Stabilization ___ A.C.T. (Assertive Community Treatment) ___ S.E.P. (Support Employment Program) ___ Family Support Services ___ Prevention

Indicate whether the child is involved with any other Human Service Agency, as applicable:
___ Department of Social Services ___ Department of Public Health ___ Substance Abuse Agency
___ Prison ___ Jail ___ Parole ___ Community Corrections ___ Courts ___ School
___ Aging Services

Is child presently receiving wrap-around services? ___ Yes ___ No

EDUCATION

Grade child is in: _____ Name of School: _____ Phone # _____

Teacher: _____ Counselor: _____ School Social Worker _____

Does child receive tutoring outside of school? ___ No ___ Yes
Has child been tested by the school for learning problems? ___ No ___ Yes
Describe the child's school attendance: _____
Has child had previous psychological testing? ___ No ___ Yes
Describe child's attitude toward school: _____
Describe child's past/current behavioral adjustment in school: _____
Describe any problems (social or academic) you think your child may have at school: _____

When/why did school behavior or academic performance change? _____

Does child work? _____ Hours per week? _____

INTERESTS/ACTIVITIES: (check all that apply to this child)

<input type="checkbox"/>	Watch TV	<input type="checkbox"/>	School	<input type="checkbox"/>	Baby-sit	<input type="checkbox"/>	Skate
<input type="checkbox"/>	Talk on phone	<input type="checkbox"/>	Be with friends	<input type="checkbox"/>	Video games	<input type="checkbox"/>	Listen to music
<input type="checkbox"/>	Ride bicycle	<input type="checkbox"/>	Play sports	<input type="checkbox"/>	Dolls	<input type="checkbox"/>	Build things
<input type="checkbox"/>	Paint	<input type="checkbox"/>	Roller blade	<input type="checkbox"/>	Collect things	<input type="checkbox"/>	Dance
<input type="checkbox"/>	Write	<input type="checkbox"/>	Draw	<input type="checkbox"/>	Read	<input type="checkbox"/>	Sing
<input type="checkbox"/>	Sew/Knit	<input type="checkbox"/>	Crafts	<input type="checkbox"/>	Imaginary Play	<input type="checkbox"/>	Action figures
	Scouting					<input type="checkbox"/>	

_____ Other

Please circle any of the following words that you might use to describe child/adolescent:

intelligent confident worthwhile ambitious sensitive loyal trustworthy full of regrets

worthless useless a nobody evil crazy morally degenerate considerate a deviant

unattractive unlovable inadequate confused ugly stupid naive honest incompetent

has horrible thoughts conflicted attractive hardworking can't make decisions has suicidal ideas

persevering good sense of humor _____ other

STRENGTHS & ABILITIES:

What do you think are your child's strengths and abilities?

Describe your family strengths & abilities: _____

Parent/Guardian Signature & Date: _____

Child/Adolescent Signature & Date: _____

Clinician Signature, Credentials & Date: _____

Clinician Name (print): _____

Medication History

1. Is child/adolescent on any medications? Yes or No (circle one please)

2. If so what medications and what are the dosages?

3. How long has child/adolescent been on this medication?

4. What symptom(s) is it targeting?

5. Who prescribed it? PCP, psychiatrist, GYN etc.

6. Is it helping? if so what percent? 10% helping 50% helping etc.

7. Is child/adolescent experiencing any side effects

8. If medication was started recently, is child/adolescent feeling significantly worse? Yes or No

Note: All of our therapists are independent contractors and are licensed and able to provide psychological assessment and treatment to children, adolescents, adults, and seniors.